	RS FOR MEDICARE	& MEDICA SERVICES	45t	人	8/01	. 10			APPROVED 0938-0391
STATEMENT OF DEFICIENCIES . (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		44A114	B. WII	NG				06/2	1/2010
NAME OF PROVIDER OR SUPPLIER LAKESHORE HEARTLAND			•	3025 F	ADDRESS, C ERNBROO		CODE	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVII	DER'S PLAN OF C DRRECTIVE ACTIV FERENCED TO TH DEFICIENCY	ON SHOU HE APPRO	LD BE	(X6) COMPLETION DATE
K 025 SS=D	Smoke barriers are least a one half hou accordance with 8.3 terminate at an atriu protected by fire-rat panels and steel fra separate compartm floor. Dampers are penetrations of smoheating, ventilating, 19.3.7.3, 19.3.7.5, 1 This STANDARD is Based on observation determined, the faci smoke and the fire by	barriers are constructed to provide at one half hour fire resistance rating in ance with 8.3. Smoke barriers may te at an atrium wall. Windows are ed by fire-rated glazing or by wired glass and steel frames. A minimum of two e compartments are provided on each ampers are not required in duct tions of smoke barriers in fully ducted ventilating, and air conditioning systems. B, 19.3.7.5, 19.1.6.3, 19.1.6.4 ANDARD is not met as evidenced by: on observation during the survey, it was ned, the facility failed to maintain the and the fire barriers as required. National tection Association (NFPA) 101, 8.3.6.1.		2	 On 06/22/10, the penetration above the duct was sealed by an outside contractor. On 06/23/10, the maintenance assistant inspected for penetrations on smoke barriers on all floors. No issues were found. Inspections will occur quarterly regarding this issue. The maintenance assistant will inspect the facility quarterly, and the Environmental Services Director will audit the quarterly inspections for 3 quarters and cease monitoring if no issues are found. 				07/13/10
K 066 SS=C	ceiling area above re revealed there was a 5" duct in the fire/sm. The deficiency was a director and later act Administrator during NFPA 101 LIFE SAF Smoking regulations less than the following (1) Smoking is prohit compartment where	verified by the maintenance knowledged by the the exit interview on 6/21/10. EETY CODE STANDARD are adopted and include no no provisions:	K 0			rifl <u>ë</u> ((X6) DATE
	Judy Grench	\circ		ļ		istrator		0	1/07/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUN SERVICES

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DEPARTMENT OF HEALTH AND HU... IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BU			5 J.I.K C.		
, 44A114		B. Win	√G_		06/21/2010			
NAME OF PROVIDER OR SUPPLIER LAKESHORE HEARTLAND				30	REET ADDRESS, CITY, STATE, ZIP CODE 1025 FERNBROOK LANE NASHVILLE, TN 37214			
(X4) ID PREFIX TAG				ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	(X5) COMPLETION DATE		
K 066	Continued From page 1 combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4		K 066		 On 06/23/10, the administ placed the oxygen sign or resident's door. On 06/23/10, the doors of residents who are on oxygen monitored and all were for have signs. On 06/23/10, the central states clerk was in-serviced regarding the place bage oxygen tubing and an oxygen tubing and an oxygen tubing staff were in-serviced regarding this new process. QA rounds will be conducted by the administrative nurse The central supply clerk weekly all rooms of residence on oxygen for the oxygen birector of Nursing versions. 	a the fall gen were bund to supply arding this s with yen sign ors. yiced dure. cted daily sing staff. will audit ents who gen signs		
	Based on inspection determined, the facil smoking regulations Protection Associated. The findings included On 6/21/10 at 9:30 Froom 412 revealed the sign at the door of a use.	not met as evidenced by: during the survey, it was lity failed to maintain the as required. National Fire on (NFPA) 101, 19.7.4. d: PM observation within resident here was 'NO - SMOKING' room where oxygen was in verified by the Maintenance			conduct random audits of for 3 months and will cea audits if no exceptions are	this issue se the		
	Director and later ac Administrator during	knowledged by the	К0	67				

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION LDING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED				
		44A114	B. WIN	IG	06/21/2010				
NAME OF PROVIDER OR SUPPLIER LAKESHORE HEARTLAND				STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE NASHVILLE, TN 37214					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION				
K 067 SS=B	Continued From page 2 ! Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on inspection during the survey, it was determined, the facility failed to maintain the heating ventilation and the cooling system as required. National Fire Protection Association (NFPA) 90A; 90B-4; 101, 19.5.2.6.1.		ΚO	1. On 06/22/10, the Environ Services Director reattach insulation cover to the du 2. On 06/23/10, HVAC duct inspected by the maintena assistant and no other issuidentified. 3. The HVAC ducts will be quarterly by the maintena assistant. 4. The Environmental Service Director will monitor the duct inspections for 3 quarterly if no iss found.	ned the ct. ts were ance les were inspected nce ces HVAC arters and				
K 147 SS=D	main mechanical rorevealed, the insulat hanging loose. The deficiency was Director and later at Administrator during NFPA 101 LIFE SAME Electrical wiring and with NFPA 70, National This STANDARD is Based on inspection determined, the facile electrical system as	PM observation within the om in the basement area tion cover on the duct was verified by the Maintenance sknowledged by the	K 14	47					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' ì	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			i 01	(X3) DATE SURVEY COMPLETED	
		44A114	B. WIN	1G				06/21	/2010
NAME OF PROVIDER OR SUPPLIER LAKESHORE HEARTLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE NASHVILLE, TN 37214						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÐ PREF TAG			PROVIDER'S PLAN EACH CORRECTIVE DSS-REFERENCED DEFIC	ACTION SHOT	ULD BE	(X5) COMPLETION DATE
K 147	The findings include On 6/21/10 at 9:30 dietary area reveals outlet. 2. At 9:40 PM obserarea revealed a harwall. The deficiency was	PM observation within the ed a loose electric receptacle rvation within the MDS office nging power-strip on the north verified by the Maintenance cknowledged by the	K	147	2.	On 06/22/10, contractor, where electrical receives to the wall. Of Environments mounted the properties of the properties of the On 06/25/10, assistant inspections and improper One additions mounting. The maintenainspect the fadeficiencies. The Environm Director will inspections for monitoring if	ho had just outlet, re-se eptacle outlet outlet outled on 06/22/10 al Services power strip e wall. the maintenected the bual receptacle use of power strance assistancility quartemental Service 3 quarter of 3 quarter	installed ecured the et properly), the Director in nance uilding for le outlets ver strips. rip required nt will erly for rices es and cease	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 44A114 08/21/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE LAKESHORE HEARTLAND NASHVILLE, TN 87214 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (D PREFIX (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG STAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 147 Continued From page 3 K 147 1. On 06/22/10, the outside electrical 07/13/10 contractor, who had just installed The findings included: the electrical outlet, re-secured the: electrical receptacle outlet properly On 6/21/10 at 9:30 PM observation within the dictary area revealed a loose electric receptacle to the wall. outlet. 2. On 06/25/10, the maintenance assistant inspected the building for 2. At 9:40 PM observation within the MDS office loose electrical receptacle outlets. area revealed a hanging power-strip on the north 3. The maintenance assistant will wall. inspect the facility quarterly for deficiencies. The deficiency was verified by the Maintenance 4. The Environmental Services Director and later acknowledged by the Director will monitor the Administrator during the exit interview. inspections for 3 quarters and cease monitoring if no issues are found. #2 07/13/10 1. On 06/22/10, the Environmental Services Director mounted the power strip in question to the wall, 2. On 06/25/10, the maintenance assistant inspected the building for improper use of power strips. One additional power strip required mounting, 3. The maintenance assistant will inspect the facility quarterly for deficiencies. 4. The Environmental Services Director will monitor the inspections for 3 quarters and cease monitoring if no issues are found

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9JGX21

Facility IQ: TN1814

If continuation sheet Page 4 of 4